Crossroads Head Start / Early Head Start
Applicant Information

Primary Adult Name _____ Date of Birth _____

Child Applicant Name _____ Date of Birth _____

I would like my child to attend Head Start/Early Head Start in _____

How many hours are needed? _____ What is your School District/Closest Elementary School? _____

Where did you hear about Crossroads Head Start / Early Head Start? _____

General Information

Living Address	City	State	Zip	County
Mailing Address (if different)	**City**	**State**	**Zip**	**County**

Phone Number	Home, Work, Cell, Other	Primary	Notes
( )		( )	
( )		( )	
( )		( )	

in Household _____ # in Family _____ Total # of Children _____ # Aged 0-3 _____ # Aged 4-5 _____

Parent in Home	Primary Language	TANF	Supp. Sec. Income (SSI)	WIC
( ) One ( ) Two	At Home	( ) Yes ( ) No ( ) Formerly	( ) Yes ( ) No	( ) Yes ( ) No

Is your family currently Homeless?	Were you referred for services by a Child Welfare Agency?	Receiving Supplemental NutritionAssistance Program (SNAP/Food Stamps)
( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

Is One or more parent/guardian a member of the US Military? ( ) Yes ( ) No Deployed? ( ) Yes ( ) No	Does applying child have a disability or special need? ( ) Yes ( ) No If yes, give diagnosis, date and source:

Notes

Emergency Contacts

Contact 1

Name	Relationship to child	( ) Emergency Contact	( ) Release Child to

Address	City	State	Zip

Phone 1	Type/Notes	Phone 2	Type/Notes	Phone 3	Type/Notes

Contact 2

Name	Relationship to child	( ) Emergency Contact	( ) Release Child to

Address	City	State	Zip

Phone 1	Type/Notes	Phone 2	Type/Notes	Phone 3	Type/Notes

Contact 3

Name	Relationship to child	( ) Emergency Contact	( ) Release Child to

Address	City	State	Zip

Phone 1	Type/Notes	Phone 2	Type/Notes	Phone 3	Type/Notes

Doctor/Dentist

Doctor/Office Name	Address	City	State	Zip

Phone Number	Fax Number
( )	( )

Dentist/Office Name	Address	City	State	Zip

Phone Number	Fax Number
( )	( )

I certify that this informatin is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the infromation in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature _____ Date _____

Verifying Staff Signature _____ Date _____

Rev 5/2014

Crossroads Head Start / Early Head Start
Family Member Information

Adult One

Last	First	Middle	Nickname/Alias	Suffix (Jr, Sr, II, III, etc)

Birthday	Gender	Primary Language	English Proficiency
	M F		( ) None ( ) Poor ( ) Moderate ( ) Proficient

Race (Check all that apply)	Employment Status ( ) Full Time ( ) Part Time ( ) Retired ( ) In School/Training ( ) Self ( ) Unemployed	Occupation/Employment
( ) Hispanic ( ) Asian ( ) White ( ) Black		
( ) Pacific Islander ( ) Native American	Education Level	( ) Lives with Child ( ) Provides Financial Support
( ) Other : _____		( ) Teen Parent ( ) Subsidized

Adult Two

Last	First	Middle	Nickname/Alias	Suffix (Jr, Sr, II, III, etc)

Birthday	Gender	Primary Language	English Proficiency
	M F		( ) None ( ) Poor ( ) Moderate ( ) Proficient

Race (Check all that apply)	Employment Status ( ) Full Time ( ) Part Time ( ) Retired ( ) In School/Training ( ) Self ( ) Unemployed	Occupation/Employment
( ) Hispanic ( ) Asian ( ) White ( ) Black		
( ) Pacific Islander ( ) Native American	Education Level	( ) Lives with Child ( ) Provides Financial Support
( ) Other : _____		( ) Teen Parent ( ) Subsidized

Child One-Applying Child

Last	First	Middle	Nickname/Alias	Suffix (Jr, Sr, II, III, etc)

Birthday	Gender	Primary Language	English Proficiency
	M F		( ) None ( ) Poor ( ) Moderate ( ) Proficient

Applying **( ) Yes ( ) No**	Race (Check all that apply)	Medicaid Eligibility ( ) On Medicaid ( ) Potentially Elig ( ) Not Elig
	( ) Hispanic ( ) Asian ( ) White ( ) Black	Medicaid Number
Nationality	( ) Pacific Islander ( ) Native American	Primary Health Coverage
	( ) Other : _____	Other Health Coverage
Relationship to Adult One		Relationship to Adult Two

Child Two

Last	First	Middle	Nickname/Alias	Suffix (Jr, Sr, II, III, etc)

Birthday	Gender	Primary Language	English Proficiency
	M F		( ) None ( ) Poor ( ) Moderate ( ) Proficient

Applying **( ) Yes ( ) No**	Race (Check all that apply)	Medicaid Eligibility ( ) On Medicaid ( ) Potentially Elig ( ) Not Elig
	( ) Hispanic ( ) Asian ( ) White ( ) Black	Medicaid Number
Nationality	( ) Pacific Islander ( ) Native American	Primary Health Coverage
	( ) Other : _____	Other Health Coverage
Relationship to Adult One		Relationship to Adult Two

Child Three

Last	First	Middle	Nickname/Alias	Suffix (Jr, Sr, II, III, etc)

Birthday	Gender	Primary Language	English Proficiency
	M F		( ) None ( ) Poor ( ) Moderate ( ) Proficient

Applying **( ) Yes ( ) No**	Race (Check all that apply)	Medicaid Eligibility ( ) On Medicaid ( ) Potentially Elig ( ) Not Elig
	( ) Hispanic ( ) Asian ( ) White ( ) Black	Medicaid Number
Nationality	( ) Pacific Islander ( ) Native American	Primary Health Coverage
	( ) Other : _____	Other Health Coverage
Relationship to Adult One		Relationship to Adult Two

Other Family Members

Adult/Child	Last Name	First Name	Birthday	Gender	Relationship

( ) Check here if there are other children in the home. If so, list on back (Please include all information, as possible)

I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature _____ Date _____

Verifying Staff Signature _____ Date _____